IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 8842

July 24, 2006

Kevin P. Ryan, Administrator
Hillcrest Haven Convalescent Center
1071 Renee Avenue
Pocatello, ID 83201

Provider #: 135018

Dear Mr. Ryan:

On **June 28, 2006**, a fire safety survey was conducted at Hillcrest Haven Convalescent Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be widespread deficiencies that constitute no actual harm, but have potential for more than minimal harm and are not an immediate jeopardy, as evidenced by the attached CMS Form 2567L whereby corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the**

CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 7, 2006**. Failure to submit an acceptable PoC by **August 7, 2006**, may result in the imposition of civil monetary penalties by **August 28, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **August 2, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **August 2, 2006**. A change in the seriousness of the deficiencies on **August 2, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 2, 2006** includes the following:

> Denial of payment for new admissions effective **September 28, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 28, 2006**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact me with your written credible allegation of compliance at the following address:

Bureau of Facility Standards — DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

If you choose and so indicate, the POC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 28, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR 488.331, you have the opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send a written request which states the specific deficiencies being disputed, and explains why you are disputing those deficiencies. This request must be received by **August 7, 2006.**

All required information should be as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

If your request for informal dispute resolution is received after **August 7, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Loretta Todd for

MARK GRIMES
Supervisor
Facility Fire Life Safety and Construction

MG/dmj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135018	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	06/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST HAVEN CONVALESCENT CTR	1071 RENEE AVE POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, type V (III) construction. The building is fully sprinklered with quick response heads. Smoke detection is installed in corridors only. There are multiple exits to grade and a small basement. The facility plans were approved in 1962 and final construction completed in January of 1963. Currently licensed for 113 SN/NF beds. The following deficiencies were cited at the above facility during the annual fire & life survey conducted on June 28-29, 2006. The facility was surveyed under the Life Safety Code, 2000 Edition, Existing Health Care Occupancy, adopted 3/11/2003, in accordance with C&R 42,483.70. This survey was conducted by: Debbie Ransom. RN,RHIT, Team Leader Keith Barkow, Health Facility Surveyor Chris Laumann, Health Facility Surveyor	K 000	The answers to ths stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and medicare programs.	

RECEIVED
AUG 01
JUL 26 2006
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Kevin Ryan | administrator | 7/27/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations it was determined that the facility failed to ensure compliance the proper closing of fire doors. 3 out of 8 doors within the fire compartment were affected. The finding included: 1. Observation at 8:50 am on 6/28/06 in the South West hallway fire doors did not latch nor secure properly. 2. Observation at 10:00 am on 6/28/06 rooms 2 & 4 in the women's secure unit, Bedroom doors would not latch and secure properly.	K 018	1.) These doors were removed and repaired by our maintenance department. They now close securely and provide a smoke barrier 2.) Every door in the facility has been checked to ensure they comply with this regulation. 3.) Doors will be checked monthly by our maintenance department and a log shall be maintained. 4.) Our maintenance department and our QA team will monitor this on their rounds. CORRECTED DATE ~~8-6-06 KB~~ 8-6-06 KB IS 8/2/06 KB. The answers to the stated deficiencies are not an admission of guilt. Therefore they cannot be used against this facility in a court of law. They are required by th Medicaid and Medicare programs.	

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K 018	Continued From page 2 Both of these observations were witnessed by survey team and maintenance supervisor.	K 018		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interviews the facility failed to ensure compliance that all smoke barriers were intact and would resist the passage of smoke. Penetrations (unsealed holes and gaps from sprinkler heads loose escutcheon plates and holes) in smoke barriers were observed. Three separate smoke compartment areas were affected by these openings affecting 75 percent of the residents and staff in the facility. Findings include: During the facility tour on 06/28/06, penetrations of smoke barriers was observed at the following times and locations:	K 025	1.) These areas in the facility have been repaired. 2.) The entire facility has been inspected for openings where may penetrate a smoke bsrrier. There were no other openings. 3.) This building will be inspected for openings in our smoke barriers on a monthly basis. 4.) Our maintenance department will perfor these inspections and a log will be kept. CORRECTED DATE ~~WITHIN~~ KB 8-6-06 IS 8/2/06 (KB) 2 The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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K 025	Continued From page 3 1. Observations at 10:15 am., Pool area woman's dressing room had two holes in ceilings . A two inch hole and a half inch hole 2. Observations at 10:20 am., Computer room had hole in ceiling next to sprinkler escutcheon plate. 3. Observations at 10:35 am., Kitchen office had a two inch hole in ceiling above water heater. The findings were verified at the time by survey team and Kitchen staff.	K 025	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations it was determined that the facility failed to ensure proper door closure requirements for hazardous area a soiled utility room.	K 029	1.) A self closing mechanism has been attached to this door. 2.) We have checked every door to hazardou areas to ensure they all are self closing doors. 3.) The Maintenance department as well as members from our QA committee will monitor this to ensure we remain in compliance. 4.) These doors are on the weekly maintenance log so they will be checked weekly. and a log will be kept. Corrected Date ~~8-6-06~~ 8-2-06 (KB) is 8/2/06 (KB)	8-6-06

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K 029	Continued From page 4 Findings include: Observations made at 10:18 am on the 6/28/06 revealed that the door to the soiled utility room was not closed. Further observation revealed that there was no self closure mechanism for this door and the door did not latch. 1 of 3 utility rooms door were affected.	K 029	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observations it was determined that the facility failed to ensure compliance to keep a fire exit door clear for emergency exit access. 1 of 9 fire exits were affected within the entire facility Findings: Observations at 10:28 am on 6/28/06 survey team revaled a kitchen utility cart was blocking the fire exit. Kitchen staff stated that they do use this space for parking utility carts and could use more room in the kitchen area. Utility cart was moved immediately by kitchen staff away from exit door. Maintenance supervisor notified of blocked exit and exit requirements for the kitchen area.	K 038	1.) The cart was moved from the area so that it did not block the fire exit. 2.) We have had inservices on the importance of keeping fire exit areas open and freely accessible at all times. 3.) We will check our fire exit doors at least weekly to ensure there is nothing blocking the fire exit. Logs of these the checks will be maintained by the maintenance. 4.) This will be monitored by our Maintenance department and our QA committee. 8-8-06 2 CORRECTED DATE (K3) ~~CORRECTION~~ IS 8/2/06 CORRECTIVE E-MAIL Received by Administrator on file.	

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K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and interview with kitchen staff on the day of the survey on 6/28/06, the facility did not assure that all exits access and corridors were provided with continuous emergency lighting. 4 to 6 kitchen staff members were affected. In the event of a emergency and power outage emergency lighting and exit signage would assist staff to exit the building in a safe manner. Findings included: Observation at 10:36 am survey team and kitchen staff observed that was no emergency lighting installed in the kitchen area.	K 046	1.) An illuminated exit sign has been installed over this door. All other exit doors have been checked to ensure the illuminated exit sign is in place. 2.) These doors are also on the weekly list of doors to check. They will be checked at least on a weekly basis and a log will be maintained. 3.) This will be monitored by the maintenance staff during their weekly rounds. CORRECTED [redacted] DATE IS 8/2/06 (KB.) The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	8-2-06
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 047		
	This STANDARD is not met as evidenced by: Based on observations found during our facility tour it was determined that the facility failed to ensure compliance and display of required exit			

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K 047	Continued From page 6 signs. 4 of 6 kitchen staff at time of survey were affected. Findings include: Observations at 10:25 am 6/28/06 survey team observed no exit sign was mounted above rear kitchen exit door. Installation of a Illuminated exit sign is required at this exit door leading to the exterior of the building.	K 047	The answers to the stated deficiencies are not an admission of guilt. Therefore, They cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on staff interviews it was determined that the facility failed to train employees who were familiar with proper emergency procedures in case of a fire. This affected the 3 of 6 kitchen staff who were present at the time of the survey. Findings include: Interviews on 6/28/06 with kitchen staff revealed	K 050	1.) Inservices have been held to ensure the dietary staff is familiar with the procedure when there is a fire. We have also posted what to do in case of a fire in the kitchen. Our dietary supervisor will give fire drill tests to her staff throughout the year to ensure the staff is prepared in case of a fire. 2.) Fire drills and inservices are held throughout the year for all employees. 3.) This will be monitored by the Plant maintenance supervisor and our dietary supervisor. Corrected Date is 8/2/06 (KB)	8-2-06

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K 050	Continued From page 7 that staff could not recount proper fire extinguishment procedures when asked by the surveyors. Nor could they identify the location or appearance of the pull handle to activate the fire suppression system. According to federal regulation it is a requirement that, staff is familiar with emergency procedures. NFPA 10.7.1.2	K 050	The answers given to the stated deficiencies are not an admission of guilt. Therefore they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations it was determined that the facility failed to ensure compliance with electrical safety regulations. The facility had 113 beds and all residents and staff were effected. Findings included: 1. Observations at 9:00 am on 6/28/06 in room 13 revealed a power surge suppressor was found lying on the top surface of the hand wash sink. The surge protector was plugged in and energized, suppling power to a television. 2. Observations at 9:08 am on 6/28/06 in room 15 revealed a power surge suppressor was lying on the top surface of the hand wash sink. The surge protector was plugged in and energized. All finding were observed by survey team and maintenance supervisor. Maintenance supervisor immediately removed the surge protectors from	K 147	1.) Inservices have been held regarding our electrical panels and the importance of ensureing they are not blocked. Signs have been posted by these panels informing staff that they cannot be blocked. 2.) The outlets above the sinks in all pateints rooms have been blocked and are not to be used. New electrical outlets have been installed away from the sink. 3.) Every room in the facility has been inspected to ensure the electrical outlets above the sink are not being used. 4.) The Plant supervisor will monitor this to ensure compliance. CORRECTED DATE IS 8/2/06 (K3.)	8-2-07

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K 147	Continued From page 8 sink areas. 3. Two instances of blocked electrical panels was observed in the kitchen and basement. All electrical panels shall have a minimum of 36 inches clear space for safe operation and maintenance of such equipment. NFPA 70 National Electrical Code 9.1.2.	K 147		
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on observations and interview with maintenance supervisor it was revealed that the facility failed to assure proper compliance of written fire watch procedures for the facility. Entire population and staff are affected within the facility without the required written fire watch procedures. Findings include: During records review and interview with maintenance supervisor on 3/28/06 at approximately 11:30am maintenance supervisor could not produce documentation for fire watch program procedures for the facility. Staff was	K 155	1.) A policy has been written informing staff what to do if the alarm system is down. Staff have received inservice on our fire watch policy. 2.) The staff will receive additional inservice on the fire watch policy when we have our fire alarm drills (one per quarter per shift). 3.) The plant supervisor will be responsible to see that employees are receiving the inservices and are knowledgable in rerard to our fire watch policy. CORRECTED DATE IS 8/2/06 (KB) The answers written to the stated deficiencies are not an admission of guilt. Therefore they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	8-2-06

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K 155	Continued From page 9 aware of what to do but no formal procedures have been written.	K 155	The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The facility is a single story, type V (III) construction. The building is fully sprinklered with quick response heads. Smoke detection is installed in corridors only. There are multiple exits to grade and a small basement. The facility plans were approved in 1962 and final construction completed in January of 1963. Currently licensed for 113 SN/NF beds. The following deficiencies were cited at the above facility during the annual fire & life survey conducted on June 29, 2006. The following deficiencies were cited during the annual Fire Life Safety survey conducted on 6/29/06. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities This survey was conducted by: Debbie Ransom. RN,RHIT, Team Leader Keith Barkow, Health Facility Surveyor Chris Laumann, Health Facility Surveyor	C 000	The answers to the stated deficiencies are not an admission of guilt and therefore cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare programs. RECEIVED AUG 01 2006 FACILITY STANDARDS	
C 229	~~02.106.02.a LIFE SAFETY CODE~~ REQUIREMENTS 02. Life Safety Code Requirements. The facility shall meet such provisions of the Life Safety Code of the National Fire Protection	C 229	Please refer to the answers to K018, K025,K029,K038 as they pertain to this deficiency. 8-6-06 wrong date typed should be 8/2/06 Administrator correction Email on file.	2 (KB)

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: administrator — (X6) DATE: 7/27/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135018	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	06/28/2006

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C 229	Continued From page 1 Association (26th ed., 1985) as are applicable to a health care facility except: a. As modified herein, the facility shall comply with the standards for "Health Care Occupancies" contained in Chapters 12. and 13, and applicable provisions of Chapters 1 through 7, Chapter 31, and Appendices A, B, and C of the Life Safety Code; or This Rule is not met as evidenced by: Refer to K018 as it relates to the facility's failure to ensure the proper closure of doors. Refer to K 025 as it relates to the facility's failure to ensure proper maintenance of smoke barriers. Refer to K 029 as it relates to the facility's failure to ensure that hazardous areas have self closing doors. Refer to K038 as it relates to the facility's failure to ensure exits were not blocked.	C 229		
C 436	02.120,10,e e. All patient/resident personal electrical appliances shall be inspected and approved by the facility engineer and/or administrator. This Rule is not met as evidenced by: Refer to K147 as it relates to the use of extension cords.	C 436	Please refer to the answers to K147 as it pertains to this deficiency. CORRECTED DATE ~~8-6-06~~ 8-16-06 APPROVED.	8-6-06 2 143